

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE

DANIEL LOVELACE AND
HELEN LOVELACE,
INDIVIDUALLY AND AS
PARENTS OF BRETT
LOVELACE, DECEASED,

Plaintiffs,

VS. 13-CV-02289-000

PEDIATRIC
ANESTHESIOLOGIST, P.
A. BABU RAU
PAIDIPALLI, AND MARK
P. CLEMONS,

Defendants.

DEPOSITION

OF

MARK CLEMONS, M.D.

February 6, 2014

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The deposition of MARK CLEMONS,

M.D. is taken on this 02/06/2014,
on behalf of the Plaintiffs,
pursuant to notice and consent of
counsel, beginning at approximately
10:00 a.m. in the law offices of
Thomason, Hendrix, Harvey, Johnson
& Mitchell.

This deposition is taken
pursuant to the terms and
provisions of the Tennessee Rules
of Civil Procedure.

All forms and formalities,
including the signature of the
witness, are waived, and objections
alone as to matters of competency,
irrelevancy and immateriality of
the testimony are reserved to be
presented and disposed of at or
before the hearing.

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I N D E X

WITNESS: MARK CLEMONS, M.D.

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1 VIDEO SPECIALIST: This is the
2 video deposition of Dr. Mark
3 Clemons. This is February 6, 2014.
4 We are on the record at 10:17.

5 Counsel, would each of you
6 please state your appearances for
7 the record which will then be
8 followed by the swearing in of the
9 witness by the court reporter.

10 MR. LEDBETTER: Mark Ledbetter,
11 counsel for Plaintiffs.

12 MR. JOHNSON: Kim Johnson for
13 Dr. Clemons.

14 MS. MAGEE: Marcie Magee for
15 Dr. Clemons.

16 MR. GILMORE: Brad Gilmore for
17 Dr. Paidipalli and Pediatric
18 Anesthesiologists.

19 MARK CLEMONS,
20 called as a witness, having been first duly
21 sworn, was examined and testified as follows:

22 DIRECT EXAMINATION

23 BY MR. LEDBETTER:

24 Q. Dr. Clemons, I'm Mark Ledbetter and
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1 DOCUMENT WAS MARKED AS EXHIBIT NO. 2
2 TO THE TESTIMONY OF THE WITNESS AND
3 IS ATTACHED HERETO.)

4 Q. Okay. And beneath it, you will see
5 that there are several pages that purport to be
6 an op note or an operatory narrative that you
7 also wrote.

8 A. **Yes, I did.**

9 Q. Okay. And Exhibit Number 3 is a
10 series of photographs that I will represent to
11 you were taken by the parents of Brett Lovelace.
12 And let me ask if you can identify any of the
13 people in the photograph -- in the photograph
14 particularly on the first page. Can you identify
15 that as Brett Lovelace?

16 A. **That is Brett Lovelace.**

17 (WHEREUPON, THE ABOVE-MENTIONED
18 DOCUMENT WAS MARKED AS EXHIBIT NO. 3
19 TO THE TESTIMONY OF THE WITNESS AND
20 IS ATTACHED HERETO.)

21 Q. Could you identify who is in the left
22 corner?

23 A. **Do not know.**

24 Q. Could that be his father, Daniel
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1 we've previously met. And I have passed to you
2 and to your counsel three items which I've
3 proposed to make exhibits to your deposition.
4 The first item is the anesthesia medication
5 record. And do you have that before you?

6 A. **Yes.**

7 (WHEREUPON, THE ABOVE-MENTIONED
8 DOCUMENT WAS MARKED AS EXHIBIT NO. 1
9 TO THE TESTIMONY OF THE WITNESS AND
10 IS ATTACHED HERETO.)

11 Q. Okay. Is that a document you have
12 previously seen or you're familiar with?

13 A. **No.**

14 Q. Okay. Do you have any reason to
15 believe that that record is inaccurate or does
16 not apply to this patient?

17 A. **I do not give any of these drugs. I'm
18 not an anesthesiologist. I've never seen this
19 record before.**

20 Q. Okay. Number 2, this is a history of
21 current problems for the patient. And do you
22 identify that as a document that you've created?

23 A. **That is my document.**

24 (WHEREUPON, THE ABOVE-MENTIONED
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1 Lovelace?

2 A. **Might be, but I do not know.**

3 Q. Okay. On the second page, who do you
4 see on the top left of the top photograph on the
5 second page?

6 A. **I believe that's the nurse
7 anesthetist.**

8 Q. Okay. That would be Grace Freeman?

9 A. **Yes.**

10 Q. Okay. And below that, do you note who
11 the blonde lady is in the picture on Page 2?

12 A. **One of the pre-op nurses.**

13 Q. Okay.

14 A. **I do not know her name.**

15 Q. Would that be her in the -- on the
16 Page 3?

17 A. **Yes.**

18 Q. Okay. And on Page 4, would that be
19 her on the top of Page 4 with Brett Lovelace?

20 A. **Appears to be.**

21 Q. Okay. And the bottom picture on
22 Page 4, is that Dr. Paidipalli?

23 A. **Looking at the bottom of the page
24 where you have -- no clue who that is.**

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1 Q. Okay, and on Page 5, who is that?

2 A. That is Dr. Paidipalli.

3 Q. Paidipalli. And on the next page, who

4 is that in the top photograph with Brett?

5 A. I think that is Dr. Paidipalli.

6 Q. Okay. And on the bottom of page -- of

7 that page, who is it?

8 A. That's me.

9 Q. Okay. And on the next page, is that

10 you also in the top and bottom photograph?

11 A. That is still me.

12 Q. And on the last page, is that still

13 you with --

14 A. Still me.

15 Q. Okay. And then on the next page, it's

16 the nurse with him, correct?

17 A. Correct.

18 Q. And on the last page, you see two

19 photographs. What is going on there or can you

20 tell?

21 A. Top one, he is yawning. The bottom

22 one, I do not know.

23 Q. Okay. But you don't know the timing

24 or the sequence of it?

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1 A. I don't understand what the question

2 is.

3 Q. Okay. All right, Sir. Now, prior to

4 today's deposition, Dr. Clemons, have you ever

5 been an expert witness in a malpractice case?

6 A. No.

7 Q. Have you ever testified either for a

8 Plaintiff against a doctor or in favor of a

9 doctor in a malpractice case?

10 A. No.

11 Q. Have you ever consulted for a

12 Plaintiff or for a Defendant in a malpractice

13 case?

14 A. I reviewed a record or two, but that's

15 about it.

16 Q. Okay. Now, let me just ask you a

17 general question about the practice of medicine.

18 Do you agree that a lack of knowledge in a doctor

19 could be dangerous in the medical field?

20 A. Medicine is an ongoing learning

21 process. Every day you learn a little something

22 new and you use it.

23 Q. But do you agree that lack of

24 knowledge as a part of your fund of information

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1 can be dangerous as you go about your daily

2 practice? Is that a good general rule that you

3 would agree with?

4 A. There is always something that you

5 don't know.

6 Q. Okay. Well, then, do you approve of a

7 lack of knowledge among medical practitioners or

8 do you think that medical practitioners should

9 yearn and seek to improve and increase their

10 knowledge?

11 A. Everyone should work to improve their

12 knowledge.

13 Q. Okay. Do you think a lack of

14 knowledge is dangerous in the medical field?

15 A. We always strive to learn more, to

16 know more.

17 Q. Okay. I understand that, but can you

18 answer my question as it is posited to you? Why

19 is a lack of knowledge dangerous or is a lack of

20 knowledge dangerous in the medical field?

21 A. A lack of knowledge, it sounds like a

22 Runsfeld question. We always need to know more

23 even under the best of circumstances.

24 Information you don't have is always important

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1 and so sometimes, you don't have everything you

2 would like and that can be a problem.

3 Q. Well, let me ask you maybe a general

4 kind of question that may move you a little

5 further with this. In this case, would the lack

6 of knowledge of some vital statistics about Brett

7 Lovelace have been dangerous such as his weight,

8 81 kilograms or 180 --

9 A. We knew his weight.

10 Q. Excuse me?

11 A. We knew his -- we knew he was

12 overweight.

13 Q. Okay. But would a lack of knowledge

14 of that have been dangerous in his case perhaps?

15 A. What is your question? You're giving

16 me a hypothetical.

17 Q. I am giving you a hypothetical, but

18 you have to answer questions that are posited to

19 you that are fair. Would a lack of knowledge of

20 the patient's weight have been dangerous? You

21 said you had that knowledge. My question is

22 simply whether a lack of it would have been

23 dangerous.

24 A. Sometimes lack of knowledge is

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1 important and you are missing it, and it is
2 important.

3 Q. Okay. Do you agree that weight is
4 important to know for a patient like Brett?

5 A. **Weight is always important to know.**

6 Q. Okay. All right. And would you agree
7 that if you had lacked knowledge of his asthma,
8 his snoring, apnea, mouth breathing, if you had
9 lacked knowledge of those things, that could have
10 been dangerous in his case, could it not have?

11 A. **We knew this.**

12 Q. So I'm asking you had you not known
13 that, could that have been dangerous to his
14 health and safety?

15 A. **But we knew this.**

16 Q. I understand you knew that, but you're
17 not answering my question. I'm the examiner, not
18 you. You're not entitled to ask yourself
19 questions you want. Do you understand that?

20 MR. JOHNSON: Well, you ask him
21 questions and then let him answer.

22 MR. LEDBETTER: He's not
23 answering them.

24 MR. JOHNSON: Well, he's

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1 one should have. If you didn't have it, it would
2 be a problem.

3 Q. Okay. Thank you. Now, had you
4 previously worked or performed surgery with
5 Dr. Paidipalli?

6 A. **I have operated with Dr. Paidipalli
7 many times.**

8 Q. Before this incident, how many times
9 had you worked with him in surgery?

10 A. **Can't count --**

11 Q. Just do your best.

12 A. **I have been operating at LeBonheur for
13 almost 20 years. You know, if I said 100, I
14 could be off by 100. I have operated with the
15 man many, many times.**

16 Q. Okay. And had you worked with Grace
17 Freeman on many occasions prior to this episode?

18 A. **Several. More than five, best I can
19 tell you.**

20 Q. Were they social acquaintances of
21 yours or people that you saw outside the context
22 of LeBonheur?

23 A. **I only work with them. Did not know
24 them otherwise.**

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1 answering them because you've asked
2 him something that he said he
3 already has -- or he knows.

4 BY MR. LEDBETTER:

5 Q. Okay. Would the lack of knowledge of
6 these -- this history have been dangerous in
7 Brett's case?

8 MR. JOHNSON: Let me ask you,
9 lack of knowledge by whom?

10 MR. LEDBETTER: By the surgeon
11 or the practitioners involved.

12 BY MR. LEDBETTER:

13 Q. Would that have been dangerous had
14 they lacked that information?

15 MR. JOHNSON: Objection.

16 MR. GILMORE: Object to the
17 form.

18 MR. JOHNSON: Objection.

19 BY MR. LEDBETTER:

20 Q. They have objected to the form. Is it
21 your testimony --

22 A. **For this particular case --**

23 Q. Yes.

24 A. **This is all important information that**

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1 Q. Okay. All right. Now -- so would it
2 say -- be fair to say that at the time of this
3 procedure, you had a certain level of comfort or
4 trust with Dr. Paidipalli and the CRNA, Grace
5 Freeman?

6 A. **Yes, it was a team.**

7 Q. Okay. And now, before the surgery on
8 March 12, 2012, Dr. Clemons, did you meet with
9 Dr. Paidipalli or Grace Freeman, the nurse
10 anesthesiologist, to discuss the anesthesia plan?

11 A. **No.**

12 Q. Did you meet with them prior to the
13 surgery to discuss the patient's medical history?

14 A. **No.**

15 Q. Okay. Were you aware prior to today
16 the specific medications that are listed on
17 Exhibit 1 that I provided to you and your counsel
18 that were used to facilitate the induction or the
19 anesthesia for this patient? Were you aware of
20 these medications?

21 A. **Anesthesia chooses the drugs they want
22 to use according to their needs -- according to
23 the patient's needs. I may ask periodically what
24 they have given just for my own knowledge, but**

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1 **no, I'm not aware of these -- actually what they**
2 **use on any given case.**

3 **Q.** Okay. So would it be fair to say that
4 prior to 3-12-2012, you did not routinely have
5 discussions with Dr. Paidipalli in prior meetings
6 about what his anesthesia medication record would
7 be?

8 **A.** **Correct.**

10:38:54 9 **Q.** Okay. All right. Now, did you have
10 any knowledge on March 12, 2012 of the prior
11 claims against Dr. Paidipalli that have been
12 raised or made for prior malpractice cases?

13 **A.** **No knowledge of any.**

10:39:16 14 **Q.** So in summary, before the operation on
15 Brett Lovelace, Dr. Clemons, you did not have a
16 knowledge of what his planned approach or
17 medications would be with your patient, Brett
18 Lovelace. You agree?

19 **A.** **No. And normally, I don't.**

10:39:28 20 **Q.** Okay. And as we sit here, you did not
21 know what drugs or dosages he used and the
22 rationale for it for the anesthesia, do you?

23 **A.** **He gives -- he decides what the drugs**
24 **are. He knows these drugs. I do not.**

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1 **Q.** Okay. Now, at the time of Brett
2 Lovelace's T&A, which I guess -- may I use that
3 as a term?

4 **A.** **Sure.**

10:39:58 5 **Q.** Okay. This T&A, did you approve of
6 the joint use of Propofol and Fentanyl?

7 **A.** **I had -- I don't tell anesthesia what**
8 **drugs to use.**

10:40:17 9 **Q.** So the answer, then, is that you did
10 not approve or disapprove of the use of Propofol
11 or Fentanyl?

12 **A.** **Correct. But I did not know what**
13 **drugs they were going to use either.**

10:40:29 14 **Q.** Dr. Clemons, were you aware on
15 3-12-2012 of the interaction of these drugs if
16 given conjointly?

17 **A.** **Which drugs are we talking about?**

18 **Q.** Talking about Propofol and Fentanyl.

10:40:47 19 **A.** **Historically, I think they have been**
20 **used together many, many times.**

21 **Q.** Were you aware of the interaction of
22 the drugs? In other words, what synergy or what
23 they --

24 **A.** **Which interaction are we talking**

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1 **about?**

2 **Q.** We're talking about any interaction
3 that the two drugs have, how one affects the
4 other, whether it exaggerates it or whether it
10:40:55 5 minimizes it.

6 **A.** **This is an anesthesia pharmacology**
7 **question. I don't know.**

8 **Q.** All right. You agree, then, you did
9 not know at the time of Brett Lovelace's surgery
10:41:12 10 what drugs were to be given by Dr. Paidipalli or
11 how they interacted and might or could adversely
12 affect Brett Lovelace?

13 **A.** **I have no knowledge of any of that.**

14 **Q.** Now, how many surgeries did you
10:41:30 15 perform on average in 2012 at LeBonheur?

16 **A.** **Probably about 200.**

17 **Q.** Did you have other surgeries scheduled
18 on 3-12 of 2012 besides this surgery?

19 **A.** **I don't believe so.**

10:41:53 20 **Q.** Okay.

21 **A.** **You know, I just don't know if I did a**
22 **case. I probably may have done a case or two**
23 **beforehand.**

24 **Q.** Okay. All right. Now, I asked you
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1 **about the drug Propofol. Do you know what the**
2 **drug Propofol is, whether it's an anesthetic or**
3 **an analgesic, or what it is?**

4 **A.** **It's a drug used for general**
10:42:17 5 **anesthesia.**

6 **Q.** And with respect to Fentanyl, do you
7 know what class it is or what kind of drug it is?

8 **A.** **It's a rapid acting narcotic.**

9 **Q.** Okay. Are you aware that Fentanyl was
10:42:30 10 and is an opiate that has 150 times the potency
11 of morphine?

12 **A.** **It is significantly more potent than**
13 **morphine.**

14 **Q.** Okay. Now, were you aware that
10:42:46 15 Propofol and Fentanyl interact and that the
16 combination delays recovery from anesthesia?

17 **A.** **Well, both are used for general**
18 **anesthesia, so certainly, they would both affect**
19 **general anesthesia.**

10:43:07 20 **Q.** My question was, were you aware that
21 the combination delayed a recovery from
22 anesthesia?

23 **MR. GILMORE: Same objection.**

24 **A.** **No.**

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1 BY MR. LEDBETTER:

2 Q. Were you aware that Fentanyl causes
3 rigidity to the muscles of respiration?

4 A. No.

5 Q. So it's true that you lack the
6 knowledge of it's use in this case, as well as
7 the fact that it is hampering respiration?

8 A. **Anesthesia decided what to use. I do
9 not know whether he used it or not.**

10 Q. Were you aware as a surgeon performing
11 this T&A that Fentanyl leaves respiratory --
12 leaves a respiratory depressant effect which is
13 evident for three to four hours?

14 A. No, I did not.

15 Q. Had Dr. Paidipalli ever discussed or
16 tell you that?

17 A. **Over the years, we've never had that
18 kind of discussion.**

19 Q. Were you aware as a surgeon in this
20 case that even a minor degree of airway
21 obstruction could be hazardous to a patient given
22 Fentanyl to put them to sleep?

23 MR. GILMORE: Object to the
24 form.

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1 Lovelace's surgery on March 12, 2012 that airway
2 compromise is the major cause of death or major
3 injury in claims that arise after a
4 tonsillectomy?

5 A. **I did not know that.**

6 Q. Were you aware that Fentanyl is
7 specifically contraindicated where there is upper
8 airway obstruction?

9 MR. GILMORE: Object to the
10 form.

11 A. **I did not know that.**

12 BY MR. LEDBETTER:

13 Q. Were you aware of that?

14 A. No.

15 Q. Were you aware that Fentanyl is
16 contraindicated where there is asthma?

17 MR. GILMORE: Object to the
18 form.

19 A. **I did not know that.**

20 BY MR. LEDBETTER:

21 Q. Were you aware that Fentanyl itself
22 can cause slow, shallow respiration and apnea?

23 MR. GILMORE: Object to the
24 form.

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1 A. Fentanyl is -- Fentanyl is commonly
2 used on people for general anesthesia. The
3 Propofol is commonly used for ENT cases because
4 it wears off so quickly. Lots of people like
5 Propofol because it's rapidly -- metabolized and
6 rapidly gone. So the use of them together is
7 not -- my sense is it's not uncommon, but not
8 being an anesthesiologist, I couldn't tell you
9 how common.

10 BY MR. LEDBETTER:

11 Q. Okay. Were you aware that a minor
12 degree of airway obstruction in a patient who's
13 undergoing surgery could be hazardous to a
14 patient who was given Fentanyl?

15 A. **All narcotics can cause some --**

16 Q. Would your answer --

17 A. **-- increase of respiration.**

18 Q. Would your answer then be yes, that
19 you were aware that a minor degree of airway
20 obstruction could be hazardous with a patient
21 given Fentanyl, an opiate?

22 A. **Airway obstruction after narcotics is
23 always a concern.**

24 Q. Were you aware at the time of Brett

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1 A. **All narcotics probably can do that.**

2 BY MR. LEDBETTER:

3 Q. Were you aware that Fentanyl
4 specifically could?

5 A. No.

6 Q. Were you aware that a dose of BIMU-8
7 or Narcan were fast acting antidotes to any
8 Fentanyl respiratory suppression?

9 A. **I don't understand what the question
10 was.**

11 Q. Are you familiar with BIMU-8 or
12 Narcan?

13 A. **Narcan, yes.**

14 Q. Were you aware that if there is a
15 respiratory suppression by Fentanyl, that that is
16 an antidote, that Narcan --

17 A. **Narcan is an antidote for narcotics,
18 correct.**

19 Q. Do you agree that it would have been
20 Dr. Paidipalli's choice to use the Fentanyl and
21 the Propofol, not yours? That was his choice.

22 A. **That would have been his choice.**

23 Q. Okay. Now, before the 3-12-2012 T&A
24 procedure that you performed on Brett Lovelace,

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1 did you ever look at the Physicians' Desk
 2 Reference to study Fentanyl's warnings?
 3 **A. No, as I don't give Fentanyl.**
 4 **Q.** Did you, on March 12, 2012, know that
 5 there were specific warnings about respiratory
 6 suppression, an alteration in the respiratory
 7 rate of patients given the drugs?
 8 **A. No, I did not know this.**
 9 **Q.** So you lack knowledge of the FDA
 10 approved warnings that applied to these drugs
 11 that were given to Brett Lovelace by
 12 Dr. Paidipalli?
 13 **A. Correct.**
 14 **Q.** Now, when Brett Lovelace reached the
 15 recovery room -- which I'm going to call PACU or
 16 I may call it recovery.
 17 **A. we prefer recovery room, too.**
 18 **Q.** Okay. It's interchangeable. He was
 19 not -- this is a question, not an answer. He was
 20 not on supplemental oxygen at that time, was he?
 21 **A. My experience at LeBonheur is**
 22 **everybody leaving the operating room is on**
 23 **supplemental oxygen.**
 24 **Q.** Do you recall him --

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1 **A. But they went to recovery room and I**
 2 **went to change my clothes, so I don't know.**
 3 **Q.** Okay. Now, when he reached the
 4 recovery room, did you give a doctor's order that
 5 he was to remain on supplemental oxygen to Nurse
 6 Kish or whoever would have been the nurse
 7 attending?
 8 **A. Generally speaking, anesthesia orders**
 9 **in the recovery room will say they should be on**
 10 **oxygen to keep their saturation up above 90 to 92**
 11 **percent.**
 12 **Q.** Okay. Did you, at any time, specify
 13 that the PACU continue supplemental oxygen for
 14 him? Did you?
 15 **A. I don't believe so.**
 16 **Q.** Okay. Did you -- when you went to the
 17 recovery room or PACU, did you visit with Grace
 18 Freeman or see Grace Freeman there?
 19 **A. I don't remember.**
 20 **Q.** Okay. Now, I have asked this same
 21 question earlier, but I'm going to ask it again,
 22 so I'm just warning you. But were you aware that
 23 Fentanyl suppressed respiration and for a patient
 24 with any upper airway or breathing problems,

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1 there was a risk of delayed respiratory
 2 suppression?
 3 **MR. GILMORE: Object to the**
 4 **form.**
 5 **BY MR. LEDBETTER;**
 6 **Q.** Were you aware of that risk of delayed
 7 respiratory suppression?
 8 **A. No, but that's why we have recovery**
 9 **rooms, so the patient can be watched.**
 10 **Q.** Okay. So you agree that when Brett
 11 Lovelace was anesthetized, you and Dr. Paidipalli
 12 had no discussion about his asthma, did you? Did
 13 you have any discussion with Dr. Paidipalli about
 14 the asthma?
 15 **A. No, but he knew he had asthma and I**
 16 **knew he had asthma.**
 17 **Q.** Did you have any discussion with him
 18 about his sleep-deprived breathing in his medical
 19 history?
 20 **A. No, but according to -- his history**
 21 **would have picked up and my history picked that**
 22 **up. That's why we do tonsillectomy and**
 23 **adenoidectomy.**
 24 **Q.** Did you have a discussion with

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1 Dr. Paidipalli about his apnea?
 2 **A. No. I don't believe the mother ever**
 3 **talked to me about apnea either.**
 4 **Q.** Did you have any discussion with
 5 Dr. Paidipalli about his snoring and mouth
 6 breathing?
 7 **A. No, but all these kids with big**
 8 **tonsils and adenoids have snoring and mouth**
 9 **breathing. There would never have been a need to**
 10 **discuss this.**
 11 **Q.** And in your note of his history, you
 12 say his tonsils are enlarged three plus. What
 13 does that mean?
 14 **A. Means they are very large, but they**
 15 **are not quite touching.**
 16 **Q.** Okay.
 17 **A. It's a relative size.**
 18 **Q.** I understand. Now, again, you had no
 19 discussion with Dr. Paidipalli about the potent
 20 opiate Fentanyl and any effect it might have on
 21 Brett's breathing, did you?
 22 **A. No.**
 23 **Q.** Did Dr. Paidipalli ever solicit your
 24 opinion on how to put Brett Lovelace to sleep and

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1 keep him safe?

2 **A. The anesthesiologist never ask the ENT**
3 **doc how to do his own job.**

4 **Q.** Did you ever ask Grace Freeman or
5 Dr. Paidipalli about what drugs they planned to
6 use?

7 **A. No.**

8 **Q.** Now, when you went to the recovery
9 room, you did not see Dr. Paidipalli there, did
10 you?

11 **A. I don't think so.**

12 **Q.** Best of your knowledge, he did not
13 accompany the patient to the recovery room, did
14 he?

10:52:58 15 **A. I don't know. I want one direction.**
16 **They went another direction.**

17 **Q.** Have you ever seen Dr. Paidipalli, in
18 these many procedures that you've had with him,
19 go with the patient to the recovery room? Have
20 you ever seen him do that?

21 **A. Yes.**

22 **Q.** Okay. Most of the time or half the
23 time? How many times?

24 **MR. GILMORE:** Object to the
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1 form.

2 **A. I have no idea. I mean, this is a**
3 **routine thing that happens every day. It's sort**
4 **of like background noise.**

5 **BY MR. LEDBETTER:**

6 **Q.** Would you say it was common for him to
7 go to the recovery room in cases that you've had
8 with him or uncommon?

10:53:43 9 **A. It's a mixed bag. Sometimes he goes.**
10 **Sometimes he doesn't.**

11 **Q.** Now, are you familiar with the Glasgow
12 Coma Scale?

13 **A. I've heard of it, but I really**
14 **don't -- I really don't know how its evaluation**
15 **is.**

10:54:00 16 **Q.** Can you give us any assessment using
17 the Glasgow Coma Scale for Brett Lovelace when he
18 was extubated?

10:54:21 19 **A. I can't do anything about the Glasgow**
20 **Coma Scale except I have heard about it.**

21 **Q.** It would be fair to say that when he
22 arrived in the recovery room or PACU, you could
23 not give us a Glasgow Coma Scale rating for him
24 there either?

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1 **A. I cannot give it to you because I**
2 **don't know what the numbers are in the coma**
3 **scale.**

10:54:50 4 **Q.** Now, you have -- in Exhibit Number 2
5 after the first page, Dr. Clemons, you have your
6 op note or your operative report.

7 **A. Correct.**

8 **Q.** Do you see that?

9 **A. Correct.**

10:54:58 10 **Q.** Okay. Now, do you know when this was
11 written? I see that the date of service was
12 March 12th, but the date it was signed was
13 March 19th. Do you know when this was written by
14 you or dictated?

10:55:29 15 **A. It probably would have been that day**
16 **or the next day, the day after surgery.**
17 **Transcription could tell you that. I don't know.**

18 **Q.** I think I see it. Turn to the last
19 page and let me ask you --

10:55:39 20 **A. Dictated.**

21 **Q.** Yeah, it's a D. Does that mean that
22 it was dictated March 12 at 5:48 p.m. or when,
23 5:48 a.m.?

24 **A. It certainly wasn't 5:48 a.m.**

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1 **Q.** Well, is that what it shows, is that
2 you dictated it before the surgery?

3 **A. No. I would never dictate anything**
4 **before a surgery.**

10:56:04 5 **Q.** Okay. But I'm saying is that what the
6 record shows?

7 **A. I don't know. I can barely tell what**
8 **it says.**

10:56:19 9 **Q.** It says D 03-12-12. That would be the
10 correct date of the surgery.

11 **A. Right.**

12 **Q.** And then it says 0548, and that would
13 be 5:00 a.m., would it not?

10:56:30 14 **A. True. But more likely, it was**
15 **dictated at 5:00 p.m.**

16 **Q.** But 5:00 p.m. would be 1748, would it
17 not?

18 **A. Correct.**

10:56:42 19 **Q.** And it shows that it's transcribed at
20 what, 6:10 a.m.?

21 **A. Right.**

22 **Q.** Okay. Who is SC?

23 **A. Person transcribing it, I guess.**

24 **Q.** Okay. So the record itself shows that
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1 it was -- it was dictated before -- dictated and
2 transcribed before the surgery; is that correct?

3 A. That's what it says, but it wasn't.

4 Q. All right. Now, did you ever go back
5 after it was dictated and make any changes to it
6 before it was made a permanent record?

7 A. Not that I know of, but I'm sure I
8 read it and might have changed a "we" to a -- I
9 change words like "we" to "I," but I couldn't
10 tell you if I changed a word or two.

11 Q. Well, do you think on the last page,
12 you might have changed the word -- the last
13 sentence from reading, "He tolerated the
14 procedure without problems" to read "He tolerated
15 the procedure itself without problems"? Could
16 you have made that change by adding the word
17 "itself" after he died or after he had problems?

18 A. Well, when I talk about the procedure,
19 I'm talking about the operative procedure.

20 Q. Right.

21 A. We did the surgery. We woke him up,
22 extubated him and took him to the recovery room.

23 Q. Well, my point is, where it says he
24 tolerated the procedure itself, do you think

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1 after he coded, that you might have added the
2 word "itself" or do you think that would have
3 occurred maybe in a later revision, or do you
4 know?

5 A. I'm not as smart as you to think about
6 that one.

7 Q. Now, in your note -- in your note
8 about the procedure, you agree that if you
9 dictated this at 5:48 in the morning, you
10 certainly couldn't predict the outcome of the
11 surgery and how well he did in it, could you?

12 A. I wasn't up at 5:45 that morning, so
13 it couldn't have been dictated at 5:48 that
14 morning.

15 Q. Then you would agree that it couldn't
16 have been dictated -- it couldn't have been
17 correct if it was dictated then, right?

18 A. It wasn't dictated then.

19 Q. Okay. Now, did you have a
20 conversation with Brett when he was in the
21 operating room and when he was extubated? Did
22 you visit with him? Did he respond to you
23 verbally?

24 A. When Brett woke up -- teenagers are

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1 likely to do this -- he started trying to climb
2 off the operating table. But -- so people were
3 there to keep him from falling off the table,
4 hurting himself. And this is common with
5 teenagers. And so we got him calmed down and he
6 woke up a little more and was breathing on his
7 own. They moved him to the stretcher and then
8 took him to the recovery room. At that point,
9 nobody is having a conversation with the patient.

10 Q. All right. At that point, did you do
11 any sort of -- you've said previously you didn't
12 know how to do an assessment under the Glasgow
13 Coma Scale. Did you do any sort of assessment of
14 him using either the modified Aldrete or the
15 Aldrete scale to determine his motor activity or
16 his mental activity or his physical activity
17 relative to pain? Did you do any assessment like
18 that?

19 A. Up until reading these reports, I had
20 never seen that second scale. And I'm in the
21 room. If there is an airway issue, I try and
22 stay in the room if there is an airway issue when
23 they extubate them. And they got the young man
24 extubated. He was breathing on his own at that

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1 point. I personally did not do an assessment
2 beyond that.

3 Q. Did you observe him being connected to
4 supplemental oxygen after the extubation? Do you
5 remember seeing that happen?

6 A. Routinely, that happens on these kids
7 and it's like I said before, this is like
8 background noise. They do it routinely and you
9 don't pay attention to it.

10 Q. Okay. Would it be fair to say that
11 you do not specifically recall in this instance
12 the moment that that did or did not occur?

13 A. Correct.

14 Q. Okay. Now, when he was extubated, do
15 you recall whether Brett Lovelace obeyed
16 commands, like look at me or nod?

17 A. I do not know.

18 Q. Is there usually a test that you give
19 a patient when they have been extubated?

20 A. Well, there are two ways to extubate
21 people. One is deep and one is awake. On little
22 bitty kids without significant airway problems,
23 they like to do it deep. On older -- on people
24 with airway problems, you like to do more awake

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1 where they can follow commands.

2 Follow commands doesn't mean you

3 and I are having a conversation. It's more of,

4 you know, raise your hand, open your eyes, you

5 know, something that says yes, the person's awake

6 enough that we could move to the next step.

7 Q. Okay. But would you say that -- which

8 sort of extubation was this? Was it deep or

9 what?

11:02:25 10 MR. GILMORE: Object to the

11 form.

12 BY MR. LEDBETTER:

13 Q. How would you characterize his

14 extubation?

11:02:31 15 MR. GILMORE: Same objection.

16 A. Not being the anesthesiologist or the

17 person giving the instructions at that moment, I

18 couldn't tell you which one they actually did.

19 BY MR. LEDBETTER:

11:02:44 20 Q. Do you agree that you do not have a

21 test that you administer to your patients in the

22 OR when they are extubated to satisfy yourself

23 about their level of consciousness?

24 A. I'm not the person doing this.

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1 Q. Okay. Now, do you agree as we are

2 sitting here, that when he was extubated and upon

3 his arrival in the PACU, did you ever see Brett

4 Lovelace's face when he was in the PACU or was

11:02:24 5 his face concealed from view?

6 A. When I got into the recovery room,

7 Brett had rolled over onto his stomach.

8 Q. So you did not, at that point, see his

9 face or observe supplemental oxygen on him?

11:03:42 10 A. I don't believe so.

11 Q. Okay. Now, were you aware on

12 3-12-2012 or today that children who are at risk

13 for sleep apnea or obstructed sleep apnea should

14 not receive more than a half dose of an opiate

11:04:06 15 such as Fentanyl because of the respiratory

16 depressant effect of the drug?

17 MR. GILMORE: Object to the

18 form.

19 A. As stated before, I'm not conversant

11:04:21 20 with Fentanyl other than knowing that it's a

21 narcotic. It's rapid acting compared to others,

22 it wears off faster.

23 BY MR. LEDBETTER:

24 Q. But you were not aware that it had a

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1 three to four-hour attenuated respiratory

2 suppressant or depressant effect?

3 A. No.

4 Q. Now, had you, prior to today, ever

11:04:47 5 read any medical articles that state that if a

6 patient has upper airway surgery, has

7 obstructions or apnea, that they should be

8 directed to the ICU for recovery under a doctor's

9 care instead of to the PACU or nursing assistance

11:05:07 10 only?

11 A. There is all sorts of literature you

12 can find. Kids and adults every day have

13 tonsillectomy and adenoidectomy for upper airway

14 obstruction and sleep apnea. In kids, generally

11:05:20 15 speaking, that is the treatment for sleep apnea.

16 The first thing that you would want to do is get

17 them awake. It's extremely rare you would send

18 someone straight to the ICU unless you had them

19 on a ventilator.

11:05:33 20 Q. Okay. Well, I mean, if they are on

21 supplemental oxygen --

22 A. Everyone is on supplemental oxygen in

23 the recovery room when they get there.

24 Q. Excuse me?

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1 A. Almost everyone is on supplemental

2 oxygen for a short while in the recovery room

3 when they get there.

4 Q. But you never saw Brett on

11:05:54 5 supplemental oxygen in the PACU, did you? You

6 said you didn't

7 A. In absolute terms, I couldn't tell

8 you.

9 Q. And whose prerogative would it have

11:06:06 10 been, yours or Dr. Psidipalli's or both of you

11 jointly, to opt for ICU for Brett Lovelace

12 instead of the PACU? Whose call was that?

13 A. Well, if a patient -- okay. In real

14 terms, patient is having immediate problems in

11:06:32 15 the operating room and you thought that you

16 really needed the ICU. You might send them

17 straight -- you might try and get them straight

18 to the ICU. But in the real world here, postop

19 tonsillectomy, adenoidectomy in a healthy child

11:06:43 20 or adult even, you would go to the recovery room.

21 And then if you were having problems, then you

22 decide to either admit them or go to the ICU.

23 Q. Okay. The question I asked was not

24 directly answered and it is, was it your

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1 prerogative or would have it have been
2 Dr. Paidipalli's prerogative or a joint
3 prerogative to have had Brett dispatched to the
4 ICU?

5 MR. JOHNSON: At what time? At
6 what time?

7 **A. At what time? When?**

8 MR. JOHNSON: At what time?
9 When?

11:07:16 10 **A. When?**

11 BY MR. LEDBETTER:

12 **Q.** After surgery.

13 MR. JOHNSON: When after
14 surgery?

15 **A. In the operating room or in the
16 recovery room or where?**

17 BY MR. LEDBETTER:

18 **Q.** Did you hear my question? I said
19 after surgery.

11:07:24 20 MR. JOHNSON: And he's asking
21 you --

22 **A. It's always my prerogative to admit
23 someone after surgery.**

24 BY MR. LEDBETTER:

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1 **Q.** Okay. That's the question I asked.
2 Now, you're aware that he ended up in the ICU
3 after he coded, correct?

4 **A. Correct.**

11:07:37 5 **Q.** Did you know Dr. Bugnitz who was in
6 the ICU?

7 **A. Never met him before.**

8 **Q.** Never met him before.

9 Okay. Have you had any sort of
11:07:47 10 discussion with him since 3-12-2012?

11 **A. We may have talked a little bit right
12 after Brett was admitted, but that's -- beyond
13 that, nothing.**

11:08:08 14 **Q.** Okay. Now, can you tell me whether or
15 not in your opinion -- or tell me what the Sims'
16 position is for a patient. Are you familiar with
17 the term?

18 **A. I don't know what the Sims' position
19 is.**

11:08:17 20 **Q.** Okay. Are you familiar with what the
21 supine position is?

22 **A. Supine.**

23 MR. JOHNSON: Do you want to
24 pronounce it right?

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1 **A. Supine.**

2 BY MR. LEDBETTER:

3 **Q.** Okay. What is that position?

4 **A. They are on their back.**

11:08:31 5 **Q.** And what is a prone position?

6 **A. On their belly.**

7 **Q.** Do you know what the Fowler's position
8 is?

9 **A. Well, Semi-Fowler's is sort of a
11:08:45 10 sitting, laying position. I don't know what the
11 Fowler's position is.**

12 **Q.** Okay. Any reason why Brett was not in
13 a Fowler's position?

14 MR. GILMORE: Object to the
11:08:54 15 form.

16 **A. Well, what is a Fowler's position?**

17 BY MR. LEDBETTER:

18 **Q.** I'm asking you if you know what it is.

19 **A. I told you I don't know what a**

11:08:58 20 **Fowler's position is. I know what Sub-Fowler's
21 is.**

22 **Q.** But you don't know what the Fowler's
23 position is?

24 **A. No.**

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1 **Q.** Do you know what a lateral position
2 is?

3 **A. On their side.**

4 **Q.** Okay. Is that -- would that have been
11:08:13 5 a proper position for Brett to have been -- been
6 in, is on his side? Would that have been an
7 effective --

8 **A. Commonly.**

9 MR. GILMORE: Object to the
11:08:20 10 form.

11 BY MR. LEDBETTER:

12 **Q.** Would that have been an effective
13 position for him to have been in?

14 **A. On the side would have been a good
11:08:30 15 position.**

16 **Q.** All right. Now, at the time that you
17 departed the PACU after Brett Lovelace's surgery,
18 did you leave any orders for the attending nurse
19 in the PACU to put him in a different position
11:08:48 20 such as a lateral position or a Fowler's
21 position?

22 **A. I don't routinely tell the nurse to
23 put them in any particular position. The
24 recovery room has its procedures to get people**

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1 awake and kids move around, but I had no -- I
2 don't believe I had any orders for any particular
3 position.

4 Q. Now, would you agree that the lateral
5 position, which is also a Sims' position I'll
6 reference, you would have been able to observe
7 whether or not Brett Lovelace's airway was
8 functional -- his upper airway was functional,
9 could you not have?

11:11:00 10 A. What you would better observe is
11 whether he was drooling or bleeding in the
12 lateral position, whether he was breathing or
13 not. I don't know that that would have helped
14 you.

11:11:09 15 Q. Okay. Now, had you left him with
16 orders for supplemental oxygen, that would also
17 have been prudent if no one had, would it not
18 have?

19 MR. JOHNSON: Objection.

11:11:24 20 A. My experience is they roll out of the
21 operating room on oxygen whether I order it or
22 not.

23 BY MR. LEDBETTER:

24 Q. But you did not verify that?

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1 A. No, I don't believe so.

2 Q. Now, when it comes to doing this type
3 of surgery, what is called a T&A, do you agree
4 that it requires, between you and the
5 anesthesiologist, a high degree of cooperation
6 because you are sharing airway?

7 A. We do share the airway.

8 Q. Okay. And you must jointly assure
9 that oxygen is provided to the patient, agree?

11:12:08 10 A. Oxygen should be provided to the
11 patient.

12 Q. And must jointly assure that carbon
13 dioxide is eliminated?

11:12:21 14 A. If you're ventilating the patient,
15 oxygen is going in and carbon dioxide is going
16 out.

17 Q. Okay. But you understand -- you agree
18 that it's your joint goal to make sure that
19 carbon dioxide is eliminated? In other words, it
20 isn't pooled so that they develop hypercapnia
21 or --

22 A. Respire. Oxygen goes in and carbon
23 dioxide goes out.

24 Q. And you must both assure that there is

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1 adequate anesthesia, correct?

2 A. Anesthesiologist is giving the
3 anesthesia. And if we get light -- which this
4 didn't happen. If we get light, then they note
5 it and they give them more anesthesia.

11:13:02 6 Q. And you also must jointly see that
7 there is a rapid return of consciousness and
8 airway reflexes after the T&A. Do you agree?

9 MR. JOHNSON: Objection. I'm
11:13:16 10 going to ask you to be more
11 specific about when after the
12 surgery. It can be 24 hours,
13 so days. I mean, when you're
14 talking about after the surgery,
11:13:27 15 please be more precise about what
16 it is that you are asking or when
17 you are asking it.

18 MR. LEDBETTER: Okay.

19 BY MR. LEDBETTER:

11:13:35 20 Q. The question that I'm going to reask
21 you will be with a view toward addressing
22 Mr. Johnson's points.

23 Do you agree that following surgery,
24 that it is crucial for the surgeon and the

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1 anesthesiologist to assure a rapid return of
2 consciousness as long as they are active and on
3 task?

4 MR. JOHNSON: Objection.

11:14:07 5 MR. GILMORE: Object to the
6 form.

7 BY MR. LEDBETTER:

8 Q. Do you agree with that?

9 A. During the operation, everyone has a
11:14:14 10 task. Okay. It's a team. Anesthesia puts them
11 to sleep, surgeon does the surgery, anesthesia
12 wakes them up and go to recovery room. Okay.
13 We're not all doing the same thing at the same
14 time.

11:14:29 15 So after doing that, we wake
16 them up. The child is breathing. If the child
17 is not breathing in the operating room, we put a
18 breathing tube back down. Now, we go to recovery
19 room. You go in the recovery room again to make
11:14:40 20 sure that they are awake. I went into -- so
21 then, again, the tasks are flowing down.

22 The recovery room nurse is now
23 watching the patient and the flow of information
24 at that point comes from the recovery room nurse

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1 when we -- after we leave.

2 Q. Do you agree with me that when you
3 last parted company with Brett Lovelace, that he
4 was not, quote, fully awake when you last saw
5 him?

6 A. Right. He was not fully awake.

7 Q. Okay. And that prior to that time in
8 the OR when he was extubated, he was not fully
9 awake either?

11:15:20 10 A. No, not awake in the sense that we
11 use -- the layman would use the term "awake."

12 Q. Okay. You never discussed sedative
13 options with Dr. Paidipalli?

14 A. I don't tell him how to do his job.

11:15:46 15 Q. Did you know that it was wise to let
16 sleep apnea patients remain in the ICU as a
17 precaution to an airway issue?

18 A. Sleep apnea patients rarely go to the
19 ICU.

11:15:59 20 Q. Really? You mean you rarely send them
21 there?

22 A. In the 30 years I have been doing
23 this, I can't remember one sleep apnea patient
24 that we sent to the ICU who woke up -- who woke

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1 up without any problems.

2 Q. How about asthma patients?

3 A. No.

11:16:33 4 Q. Asthma is an incurable disease. Do
5 you agree? It has no --

6 A. It's a chronic disease. It's a
7 chronic disease.

8 Q. But it's not curable, is it?

9 A. Not to my knowledge.

11:16:39 10 Q. And do you agree that surgery can be
11 an iatrogenic trigger for it? It can trigger
12 asthma.

13 A. Much of the anesthesia they use
14 actually will make the asthma component better,
15 at least while they are giving the particular
16 drugs.

11:16:58 17 Q. Before this surgery when you saw him
18 in the office on the 5th of March, I believe, or
19 any time thereafter, did you perform any
20 spirometry on him or send him out to a third
21 party for spirometry?

22 A. No, no, that's not routine.

23 Q. Now, were you aware on 3-12-2012 that
24 in a group of 50 percent -- that in a group of

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1 children with OSA, that -- who were given
2 Fentanyl, 50 percent of the group developed
3 complete apnea as a result of the use of
4 Fentanyl?

11:17:45 5 MR. GILMORE: Objection to the
6 form and foundation.

7 BY MR. LEDBETTER:

8 Q. Did you know that?

9 A. No.

11:17:51 10 Q. In the prescription for 200 milligrams
11 of Fentanyl, if that had been -- that dosage had
12 been halved, what would it have been?

13 A. Half of 200 is 100.

14 Q. Okay. And you weren't aware of any
11:18:13 15 medical literature that discussed having the
16 Fentanyl dosage in patients who had a history of
17 OSA?

18 A. No.

19 Q. Now, on March 12, 2012, Dr. Clemmons,
11:18:41 20 did you follow any specific extubation criteria
21 or were you aware of one that Dr. Paidipalli was
22 following?

23 A. No. I leave it to the

24 anesthesiologist to decide when to extubate the

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1 patient.

2 Q. And do you agree that on March 12,
3 2012 that asthma, sleep-deprived breathing,
4 obesity, hypertrophic tonsils and apnea were
11:19:06 5 among the medical history items that had been
6 brought to your attention by Brett Lovelace's
7 parents?

8 A. Correct.

9 Q. Now, do you agree that if he had been
11:19:14 10 extubated in a fully awake condition, once his
11 airway was restored and had been kept in a
12 Fowler's position or upright on supplemental
13 oxygen, that it's unlikely that what happened
14 here would have occurred?

11:19:40 15 A. Conjecture. Don't know.

16 Q. You don't know. Let me ask you this:
17 Are you aware of the use of each of these
18 different means? In other words, extubated and
19 fully awake, are you aware -- do you know what
11:19:53 20 that means?

21 A. When they say extubated and awake,
22 that means being able to follow commands. It is
23 not fully awake like you and I talking to each
24 other.

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1 Q. But do you understand what extubated
2 and fully awake means?

3 A. I think I do.

4 Q. Okay. Do you know what being kept in
5 an upright Fowler's position means? Do you
6 understand what that means?

7 A. You still haven't told me what a
8 Fowler's position is.

11:20:24 9 Q. It's seated. It's seated and it
10 varies from 15 to 90 degrees.

11 A. Okay.

12 Q. You got it?

13 A. Got it.

11:20:31 14 Q. Okay. And you understand what
15 supplemental oxygen is because you're familiar
16 with it being used.

17 A. Correct.

18 Q. Okay. All right. These are various
19 things that did not occur in this patient, to
20 your knowledge, correct?

21 MR. JOHNSON: What things?

22 MR. LEDBETTER: Excuse me?

23 MR. JOHNSON: What things?

24 MR. LEDBETTER: I just want

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1 through them.

2 MR. JOHNSON: Well, do it
3 again.

11:20:53 4 MR. LEDBETTER: Extubated and
5 fully awake.

6 BY MR. LEDBETTER:

7 Q. He was not extubated and fully awake,
8 was he?

11:21:00 9 A. According to what I understood. He
10 was following commands, though.

11 Q. He was not kept in an upright
12 position, was he?

13 A. Not in the recovery.

11:21:12 14 Q. And you did not witness him being on
15 supplemental oxygen in the recovery room, did
16 you?

17 A. I don't know whether he was or wasn't.

11:21:27 18 Q. Okay. You're also aware that a
19 patient can be sent to the ICU instead of the
20 PACU at LeBonheur, if you had ordered it? You're
21 aware that that's possible?

22 A. Yeah. That's conceivable, unlikely,
23 yeah.

24 Q. Okay.

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1 A. Though all the monitoring done in the
2 ICU is the same monitoring they do in the
3 recovery room.

4 MR. JOHNSON: In ICU.

5 A. It's the same monitoring either place.

6 BY MR. LEDBETTER:

7 Q. But they are physicians instead of
8 nurses and that does make a difference.

9 Otherwise, we would have nurses open --

10 A. No. The physician is not the person
11 monitoring. It's the nurse.

12 Q. So what you're saying is there was no
13 reason to or no need to send him to ICU until he
14 coded?

11:22:29 15 A. Correct.

16 Q. Okay. Now, were you aware on
17 3-12-2012 that the proper post-op position for a
18 tonsilectomy is the lateral prone with the head
19 to one side?

11:22:41 20 A. That is the preferred position.

21 Q. Okay. And would you agree that on
22 3-12-2012, that a patient with sleep apnea should
23 avoid intraoperative opiates, but where given,
24 should be completely awake with intact reflexes

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1 and normal ventilatory patterns before
2 extubation?

3 MR. GILMORE: Objection.

4 A. Read the question again.

11:23:08 5 BY MR. LEDBETTER:

6 Q. Were you aware that on March 12, 2012,
7 that patients with sleep apnea should avoid
8 intraoperative opiates?

9 MR. GILMORE: Same objection.

11:23:18 10 A. No.

11 BY MR. LEDBETTER:

12 Q. Were you aware that the same patients
13 should be completely awake with intact reflexes
14 and normal breathing before they're extubated?

11:23:29 15 MR. GILMORE: Objection.

16 A. Routinely with sleep apnea -- and I
17 deal with a lot of adults with sleep apnea -- you
18 extubate them and then you follow them with the
19 monitors, the oxygen, the monitors, the EKG, the
20 CO2 monitor, and most of them do just fine right
21 then.

22 Q. But you have them sitting up, do you
23 not, or in a --

24 A. No, they are not sitting up. No one

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1 is sitting up.

2 Q. They are in the lateral position?

3 A. Usually, the lateral position or
4 laying down.

5 VIDEO SPECIALIST: We are off
6 the record at 11:15.

7 (Brief break)

8 VIDEO SPECIALIST: We are back
9 on the record at 11:21.

11:30:48 10 MR. LEDBETTER: Do we need to
11 re-identify or are we okay?

12 VIDEO SPECIALIST: You're good.

13 MR. LEDBETTER: We just go on?

14 VIDEO SPECIALIST: Just go on.

11:30:51 15 BY MR. LEDBETTER:

16 Q. Dr. Clemons, I don't mean to put
17 myself back in reverse and go back and continue
18 to beat something to death, but I just have a
19 series of questions that should be fairly simple
20 to answer. In your op note, are there any late
21 entries in it, to your knowledge? In other
22 words, any entries that would not have been made
23 in the first draft?

24 A. Not to my knowledge.

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1 Q. Are you aware that the JCAHO requires
2 that late entries must indicate that they are by
3 a late entry?

4 A. What do you consider a late entry?

11:31:36 5 Hang on. Hang on. When you look at an op note,
6 you're supposed to review it before you signed
7 it --

8 Q. Right.

9 A. -- to make sure it is correct.

11:31:45 10 Q. And so what you are saying is that
11 "itself" is not a late entry?

12 A. That would be my concern because when
13 you dictate --

14 Q. Your interpretation.

11:31:53 15 A. -- it, sometimes there is misspellings
16 or other things that you can't correct until you
17 review it.

18 Q. Okay. But if you then sign it and go
19 back and change it, you think that would be a
20 late entry?

21 A. Correct.

22 Q. Okay. Now, with respect to the
23 decision to send Brett Lovelace to the PACU or
24 the ICU, do you agree that that would have been a

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1 choice that you had yourself? You had that
2 choice?

3 A. It's extremely rare to send someone
4 from the operating room to the ICU.

11:32:30 5 Q. But do you agree that the choice was
6 yours?

7 A. I would have had to call the ICU.
8 attending and talk to him and explain to him why
9 I wanted to send a patient up there, and he would
10 have to accept it.

11:32:40 11 Q. Again, my question is, the choice
12 would have been yours to do?

13 A. Correct.

14 Q. And with respect to choosing an
11:32:52 15 anesthesiologist who had no record of suits, you
16 had a right to ask for an anesthesiologist who
17 has no previous record of malpractice suits,
18 didn't you?

19 MR. GILMORE: Objection.

11:32:55 20 A. I didn't know I had that right.

21 BY MR. LEDBETTER:

22 Q. Okay.

23 A. I call up and ask for a -- schedule a
24 case and the department decides who my anesthesia

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1 is.

2 Q. You had a right to choose not to allow
3 the anesthesia medications, one or more of them
4 that were given, did you not?

11:33:21 5 A. I don't tell anesthesia how to do
6 their job because I don't know how to do their
7 job.

8 Q. Had you ever done any research to
9 determine the safety and efficacy of Propofol and
10 Fentanyl as anesthetic agents?

11:33:36 11 A. No.

12 Q. And were you aware that at the time he
13 was anesthetized, that he had some upper
14 respiratory compromise going on at the time the
15 surgery began?

16 A. When he was asleep, he had a good
17 airway. He was breathing very well.

18 Q. Are you aware that you had a right to
19 choose the use of supplemental oxygen in the PACU
11:34:16 20 had you wanted to choose or specify that?

21 A. Supplemental oxygen is on the list of
22 orders that I -- is on the lists of orders,
23 correct.

24 Q. Okay. I don't see it on the list of
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1 orders for the PACU, so I'm asking you if you had
2 a right to choose supplemental oxygen?

3 **A. It's an order that I could do.**

4 **Q.** Okay. And you agree that you had a
5 right to choose whether he was -- whether Brett
6 Lovelace was in the lateral or the Sims' or the
7 Fowler's position in the PACU, had a right to
8 specify those positions as his surgeon, correct?

9 **A. I could have ordered positions, but**
10 **leave it to the ICU (sic) nurses because the**
11 **patients tend to be moving around.**

12 **Q.** Do you agree that you had a right to
13 choose to read before the surgery and to learn
14 any information about the narcotics and opiates
15 that were used with Brett, but chose not to read
16 about them?

17 **A. I did not choose not to read about**
18 **them.**

19 **Q.** But you didn't choose to read about
20 them, did you?

21 **A. I did not make any -- I did not look**
22 **up these drugs to see how they had this effect.**

23 **Q.** And was one of the indications, I
24 guess, is the term for the surgery, the T&A

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1 procedure, the fact that Brett Lovelace had what
2 has been referred to as sleep-deprived breathing?

3 **A. Sleep-deprived breathing, I've not**
4 **heard that term.**

5 **Q.** It's in a 2011 clinical guideline for
6 ENT physicians, isn't it?

7 **A. Referred to his upper airway -- upper**
8 **airway obstructions. Sleep-deprived breathing.**

9 **Q.** Have you ever read the clinical
10 guideline for ENT surgeons for tonsillectomies
11 that came out in 2011?

12 **A. Not that particular guideline.**

13 **Q.** Now, in your -- in Exhibit Number 2,
14 it says toward the bottom for tonsillectomy and
15 adenoidectomy, discussed the risk of anesthesia.
16 Did you specifically discuss with the parents the
17 fact that Brett would be given Fentanyl and
18 Propofol?

19 **A. What I tell the families are there is**
20 **always a potential risk from anesthesia. Not**
21 **knowing what drugs the patient is going to get, I**
22 **can't go into that kind of detail.**

23 **Q.** Okay. Now, in July of 2013, I served
24 upon your attorneys requests for admissions and I

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1 did not get an answer or objection to these until
2 December of 2013, over five months later. Are
3 you aware of that?

4 **A. No.**

5 **Q.** Okay. Can you tell me why neither you
6 or your attorneys took five months to respond to
7 requests for admission that were submitted to you
8 by Plaintiff on July 3, 2013?

9 **A. I have no idea.**

10 **Q.** Can you tell me whether or not you
11 ever received for your signature, before
12 December of 2013, a set of responses to sign to
13 my requests for admissions that were sent to you?

14 **A. I don't know.**

15 **MR. JOHNSON:** Objection.
16 You're misstating what's required
17 of a response to a request for
18 admission.

19 **MR. LEDBETTER:** That's all. I
20 want to make these exhibits. I
21 would also like to make Exhibit 4
22 the late provided CV of
23 Dr. Clemmons.

24 (WHEREUPON, THE ABOVE-MENTIONED
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1 DOCUMENT WAS MARKED AS EXHIBIT NO. 4
2 TO THE TESTIMONY OF THE WITNESS AND
3 IS ATTACHED HERETO.)

4 **MS. MCGEE:** This actually was
5 the same one that was provided
6 previously to you with discovery;
7 however, as a courtesy to you --

8 **MR. LEDBETTER:** I didn't have
9 it.

10 **MS. MCGEE:** -- as a courtesy to
11 you, I brought it today.

12 **MR. LEDBETTER:** I stand
13 corrected, but I didn't have it.

14 **MR. JOHNSON:** Well, it wasn't
15 late provided. It was provided
16 earlier, but it was supplementally
17 provided today because we knew you
18 would show up without it. How's
19 that?

20 **MR. LEDBETTER:** Thank you.

21 **MR. JOHNSON:** Okay. Now, let
22 me ask --

23 **MR. LEDBETTER:** I'm glad you
24 are demonstrating prudence.

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1 MR. JOHNSON: Let me ask
2 Dr. Clemons --
3 CROSS-EXAMINATION
4 BY MR. JOHNSON:
5 Q. Dr. Clemons, you were asked some
6 questions about who assigns anesthesia when you
7 schedule surgery and it sounded like that y'all
8 were talking over each other, and I'm not sure we
9 cleared that up. When you or your office
10 schedules surgery, who schedules the
11 anesthesiologist or anesthesia?
12 A. I suspect the anesthesia department
13 itself decides who is going to do which cases
14 depending on needs and skills.
15 Q. Okay. So that's not something,
16 though, that you, Dr. Clemons, take upon yourself
17 to go and decide who is going to be administering
18 anesthesia; is that true?
19 A. No.
20 Q. Is that true?
21 A. That's true.
22 Q. Thank you.
23 MR. GILMORE: No questions.
24 MR. LEDBETTER: No more

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1 questions.
2 VIDEO SPECIALIST: This is the
3 end of Tape 2 of two tapes.
4 Counsel did waive the formal
5 reading of the caption. We are off
6 the record at 11:32.
7 (WHEREUPON, THE DEPOSITION WAS
8 CONCLUDED AT APPROXIMATELY 11:40 A.M.
9 AND FURTHER DEPONENT SAITH NOT.)
10 (SIGNATURE NOT WAIVED.)
11
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1 ERRATA SHEET
2 I, the undersigned,
3 do hereby certify that I have read the foregoing
4 deposition, and that to the best of my knowledge,
5 said deposition is true and accurate with the
6 exception of the following corrections listed
7 below:

8 Page No. Line No. Correction

9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____

17 _____
(Deponent)

18 _____
(Date)

19 SWORN TO AND SUBSCRIBED before me, this ____
20 day of _____, 2014.

21 _____
Notary Public

22 My Commission Expires:
23 _____
24 _____

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1 C E R T I F I C A T E
2 STATE OF TENNESSEE
3 COUNTY OF SHELBY:
4 I, PEPPER GLENN, Court Reporter
and Notary Public, Shelby County, Tennessee,
CERTIFY:

5 The foregoing proceedings were
6 taken before me at the time and place stated in
7 the foregoing styled cause with the appearances
as noted.

8 Being a Court Reporter, I then
9 reported the proceeding in Stenotype, and the
10 foregoing pages contain a true and correct
transcript of my said Stenotype notes then and
there taken.

11 I am not in the employ of and am
12 not related to any of the parties or their
counsel, and I have no interest in the matter
involved.

13 I further certify that in order
14 for this document to be considered a true and
15 correct copy, it must bear my original signature
and that any reproduction in whole or in part of
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16 Witness my signature this the ____
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21 My Commission Expires:
October 18, 2014

22
23
24

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